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JAMES W. ZIGLAR,
Petitioner,
v.
AHMER IQBAL ABBASI, *et al.*,
Respondents.

JOHN D. ASHCROFT, former Attorney General, *et al.*,
Petitioners,
v.
AHMER IQBAL ABBASI, *et al.*,
Respondents.

DENNIS HASTY, *et al.*,
Petitioners,
v.
AHMER IQBAL ABBASI, *et al.*,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF MEDICAL AND OTHER SCIENTIFIC AND HEALTH-RELATED PROFESSIONALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS AND AFFIRMANCE

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INTEREST OF *AMICI CURIAE*

Amici are a group of medical and other scientific and health-related experts from the United States and numerous other countries with extensive experience studying the psychological and physiological effects of solitary confinement and other punitive conditions of incarceration.[1] Amici have spent decades documenting these health effects and advocating on behalf of prisoners before courts, legislatures, and international and foreign legal bodies. Amici include a member of the United Nations Subcommittee for the Prevention of Torture, experts from the World Health Organization and World Psychiatric Association, preeminent psychologists and psychiatrists specializing in the effects of solitary confinement, prison health services experts and monitors, neuroscientists, physicians, and medical professors.[2]

Amici's commitment to evaluating and addressing the health effects of solitary confinement gives them a strong interest in the resolution of this case, in which Respondents seek damages to redress

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[1] Amici obtained written consent to file their brief from Petitioners and Respondents, copies of which accompany this submission, as required by Rule 37.3(a). Amici state in accord with Rule 37.6 that this brief was not authored, in whole or in part, by counsel for any party. Further, no monetary contribution to the preparation or submission of this brief was made by any person or entity other than Amici and their counsel.

[2] A detailed identification of the nineteen Amici appears in Appendix A.

their indefinite and prolonged detention in solitary confinement solely based on their race or religion and the commission of immigration infractions. Based on decades of study, experience, and advocacy, Amici are uniquely positioned to discuss the medical and other scientific and health-related literature, international legal standards, and foreign laws regarding the use of solitary confinement as imposed in this case.

Accordingly, Amici respectfully submit this brief in support of Respondents to detail the established, well-documented, and exhaustive medical and other scientific and health-related research, spanning decades and countries, that virtually unanimously concludes that prolonged solitary confinement, for more than a few weeks, inflicts profound psychological and physiological damage on inmates, or in this case, detainees held without charge. Moreover, as Amici explain below, because of the intense pain and suffering caused by solitary confinement, international legal standards and the laws of other countries restrict its use to a measure of last resort, and would prohibit its use under the circumstances of this case. Amici urge this Court to hold similarly.

BACKGROUND

The term "solitary confinement," as used in the international medical and legal literature and throughout this brief, refers to "the confinement of prisoners for 22 hours or more a day without meaningful human contact." G.A. Res. 70/175, Rule 44 (Dec. 17, 2015) ("Mandela Rules"); *see also* Craig

Haney, *Mental Health Issues in Long Term Solitary and "Supermax" Confinement*, 49 Crime & Delinq. 124, 125-27 (2003) ("Haney, *Mental Health Issues*") (defining solitary confinement as an inmate's "physical[] segregat[ion] from the rest of the prison population" and lockdown in a tiny cell of usually no more than 80 square feet for 23 hours or more per day); Juan E. Méndez, Interim report of the Special Rapporteur of the Human Rights Council on torture & other cruel, inhuman or degrading treatment or punishment, U.N. Doc. A/66/268, 8 (Aug. 5, 2011) ("Méndez 2011 Report") ("solitary confinement" is "the physical isolation of individuals who are confined to their cells for 22 to 24 hours a day"); Am. Psych. Ass'n, *Position Statement on Segregation of Prisoners with Mental Illness*, 2 (2012) ("APA Position Statement") ("segregation units . . . [have] one to two inmates in a cell").

Cells used for solitary confinement are "designed to minimize human contact and environmental stimulation." Am. Pub. Health Ass'n, *Solitary Confinement as a Public Health Issue*, 1 (Nov. 5, 2013), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue ("APHA, *Solitary Confinement*"). Accordingly, prisoners in solitary confinement routinely are deprived of almost all meaningful perceptual, social, and occupational stimulation, including natural light, most or all personal property, and almost all human interaction (which is vital to maintain a sense of identity and grasp of reality), except that which "occurs through bars or . . . slots in solid metal doors." *Id.* They also are denied access

to vocational, educational, and recreational programs. Haney, *Mental Health Issues* at 127.

The use of solitary confinement—particularly the kind of segregated housing unit ("SHU")[3] or "supermax" facility in which Respondents were housed in 2001-2002—has exploded over the past several decades across the United States. In 2000, "there were approximately 20,000 prisoners confined to supermax-type units in the United States." *Id.* at 125. By 2016, that number multiplied to "approximately 80,000 inmates . . . held in some form of isolation in state and federal prisons on any given day." National Commission on Correctional Health Care *Position Statement: Solitary Confinement (Isolation)*, 1 (Apr. 2016) ("NCCHC, *Position Statement*").

The Respondents in this case were placed in solitary confinement, in a federal SHU facility, even though they had not been charged with—much less convicted of—any crime. Fourth Amended Complaint & Demand for Jury Trial, *Turkmen v. Ashcroft*, 02-cv-2307 (E.D.N.Y. Sept. 3, 2010), ECF No. 726 ("Compl.") at ¶¶ 4, 52. Picked up in the weeks following September 11th, they were detained and isolated solely because they were non-citizens who were, or were perceived to be, Arab or Muslim and had committed civil immigration infractions. *Id.* ¶¶ 1, 29, 43. Although there was no individualized evidence that they had terrorist ties, they were held indefinitely in solitary confinement for 2.5 to 8

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[3] Throughout this brief, Amici employ the same abbreviations used in Respondents' Brief.

months in each case, until the federal government ultimately cleared them. *Id.* ¶¶ 1, 41, 142, 152, 170, 174, 188, 200, 211, 217-18, 227, 234, 237.

The extreme and punitive conditions to which Respondents were subjected squarely qualify as the kind of "prolonged" solitary confinement—*i.e.*, "longer than 3 to 4 weeks"—known to inflict severe health consequences. NCCHC, *Position Statement*, at 1. Each detainee was confined to a "tiny cell[]" for "at least 23 hours a day," alone or with one other detainee, for months on end.[4] Compl. ¶¶ 5, 76, 163, 182, 188, 211, 234. The cells were completely "bare"; no property, not "even toilet paper" or "other personal hygiene items," were kept in the cells. *Id.* ¶¶ 76, 103, 130. "[B]right lights were kept on in the cells . . . 24 hours a day," causing sleep deprivation, and the cells were "very cold at night." *Id.* ¶¶ 76, 119, 223. For the first month, the detainees were "denied all recreation" outside their cells and subjected to a "communications blackout" forbidding "any social or legal visits or telephone calls." *Id.* ¶¶ 79, 122. Even after the bans were lifted, the detainees were deterred from recreation by the extreme cold in the outdoor recreation "cages," subjected to grossly humiliating mandatory strip-searches, suffered abuse in transport, and were routinely denied the weekly legal calls and monthly social calls technically permitted. *Id.* ¶¶ 83, 111-18, 122.

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[4] Three of the six remaining Respondents were confined *alone* for all or part of their months in the SHU: Benatta for 5 months, Bajracharya for 2 months, and Khalifa for 1.5 months. Compl. ¶¶ 182, 188, 206, 212, 234.

Thus, the facts and circumstances of the Respondents' arrest and detention, combined with the conditions imposed on them during such detention, maximized their social isolation and all but eliminated environmental stimuli and meaningful activity. These conditions "exert[ed] maximum pressure" on them, and were designed specifically to inflict pain and suffering and, ultimately, to "'break[]'" them. *Id.* ¶¶ 61, 77.

SUMMARY OF ARGUMENT

The wealth of medical and other scientific and health-related research examining the consequences of prolonged use of solitary confinement overwhelmingly concludes that it inflicts profound psychological damage. Studies across nations and decades conclude that the social isolation, sensory deprivation, and extreme idleness inherent in solitary confinement is psychologically toxic and deprives inmates of the basic human needs to function. This leads to dramatic mental deterioration, even in previously healthy individuals.

As a result, an inordinately high percentage of inmates in solitary confinement exhibit a set of psychopathologies which many medical professionals describe as unique and not present in any other syndrome. These symptoms include difficulties with thinking and memory, stupor, obsessional thinking, inability to tolerate external stimuli, hallucinations, and, in extreme cases, a delirium with associated psychotic symptoms. As a result of the psychological toll, inmates in solitary confinement disproportion-

ately engage in high rates of self-mutilation and suicide. Even for those eventually released, the damage is often permanent.

Medical research also documents that prolonged solitary confinement can inflict grave physiological harms. As with psychological symptoms, reports of physical symptoms are consistent across decades and countries and include serious sleep disturbances, profound lethargy, dizziness, and deterioration of cardiac, musculoskeletal, gastrointestinal, and genitourinary function. The extreme deprivations of solitary confinement may even alter the physical structure of the brain. Again, the physiological damage is often permanent.

In recognition of the severe pain and suffering inflicted by prolonged solitary confinement, international legal institutions have condemned its use for over 15 days as cruel and inhuman treatment and, in some cases, as torture. Moreover, international bodies limit even short-term solitary confinement to a measure of last resort. They do not permit its use on the basis of race or religion or for immigration infractions. Laws of many other countries reflect these international legal restrictions on the use of solitary confinement, including, for example, the laws of England and Wales, Germany, France, Austria, Hungary, Finland, Ireland, Canada, Australia, Japan, China, and Argentina. Thus, both international legal standards and the laws of other countries prohibit the use of indefinite, prolonged solitary confinement under the circumstances of this case.

This country's laws likewise forbid the imposition of extreme and punitive conditions of confinement for discriminatory reasons and without sufficient cause, just as the Second Circuit held below. *See* Opinion, at 32, *Turkmen v. Hasty*, No. 13-981 (2d. Cir. Jun. 17, 2015), ECF No. 266. Upholding those laws is imperative not simply to redress the harms suffered by Respondents but to clarify the law going forward. Given the current political climate and rhetoric broadly connecting immigrants with the specter of terrorism, this Court's decision will have direct implications for the treatment of non-citizens in this country in the years to come. For these reasons, Amici respectfully request that the Court affirm the decision below and permit Respondents to pursue their constitutional challenges to the extreme and punitive conditions of their confinement.

ARGUMENT

I. The Medical and Other Scientific and Health-Related Literature Establishes that Solitary Confinement Causes Severe Psychological and Physiological Harms

A. Research Demonstrates that Solitary Confinement Causes Grave Psychological Damage

The extensive research conducted in prison systems throughout the United States and in many other countries is "remarkably consistent" in its findings that prolonged solitary confinement inflicts "deleterious psychological effects." Elizabeth Bennion, *Banning the Bing: Why Extreme Solitary Confinement is Cruel & Far Too Usual Punishment*, 90

Ind. L. J. 741, 756 (2015) ("Bennion, *Banning the Bing*"); *see also* Hernán Reyes, *The worst scars are in the mind: psychological torture*, 89 Int'l Rev. of the Red Cross, No. 867, 591, 607 (Sept. 2007) ("Being confined for prolonged periods of time alone in a cell has been said to be the most difficult torment of all to withstand."). In fact, "[n]early every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies." Kenneth Appelbaum, *Am. Psychiatry Should Join the Call to Abolish Solitary Confinement*, 43 J. Am. Acad. Psychiatry & L. 406, 410 (2015) ("Appelbaum, *Abolish Solitary*"). When inmates are subjected to solitary confinement for longer periods—*i.e.*, months, years, or decades—the risks of profound, permanent psychological damage skyrocket. Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J. of L. & Pol'y 325, 346 (2006) ("Grassian, *Psychiatric Effects*").

The direct link between solitary confinement and severe psychological harm has been "convincingly documented" in many countries since the nineteenth century. Int'l Psychol. Trauma Symp., *Istanbul Statement on the Use & Effects of Solitary Confinement*, 2 (Dec. 9, 2007), http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf. ("Istanbul Statement"). For example, between 1854 and 1909, 37 reports in Germany alone identified solitary confinement as the central cause of psychotic illness among prisoners. Sharon Shalev, *A Sourcebook on Solitary Confinement*, Mannheim Centre for Criminology, London School of Economics

and Political Science, 10 (Oct. 2008) ("*Sourcebook*"). This documented correlation led German officials to call for reform of the use of solitary confinement. *Id.* England likewise reformed its solitary confinement policies in the nineteenth century after documenting extraordinary increases in psychological disturbances among isolated prisoners. *See* U.R.Q. Henriques, *The Rise & Decline of the Separate System of Prison Discipline, Past & Present*, 86 (1972). Studies from Canada, Denmark, Norway, South Africa, and Switzerland, as well as several communist nations during the Cold War, recorded similar substantial increases in the prevalence of psychiatric health problems among isolated prisoners. Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 Crime & Just. 441, 481-87 (2006) ("Smith, *Effects of Solitary*").

The well-established psychological harms inflicted by solitary confinement are a direct result of its inherent characteristics: "isolation" from other people, lack of meaningful perceptual stimulation, and extreme "idleness" resulting from the denial of any productive activities. *See* Terry Kupers, *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?*, Routledge Handbook of Int'l Crime & Just. Stud., 5-6 (2013) ("Kupers, *Isolated Confinement*"). As explained by Dr. Terry Kupers, "[h]uman beings require at least some social interactions and productive activities to establish and sustain a sense of identity and to maintain a grasp on reality." *Id.* at 6. When a person is deprived of meaningful social contact and activity, "unrealistic ruminations and beliefs cannot be tested" and "are transformed into unfocused and

irrational thoughts." *Id.* "[D]eprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment." Grassian, *Psychiatric Effects*, at 331. This inability to concentrate can render isolated prisoners unable to read or watch television even when such pastimes are permitted (and they often are not). Smith, *Effects of Solitary* at 490. "Internal impulses" grow to "overwhelming proportions," without check, and "[d]isorganized behaviors emerge." Kupers, *Isolated Confinement*, at 5.

Recognizing the direct link between solitary confinement and the harms it causes, experts advise that "the inherent restriction in meaningful social interaction and environmental stimulation and the lack of control adversely impact the health and welfare of *all who are held in solitary confinement*." NCCHC, *Position Statement*, at 2 (emphasis added). Even previously healthy, stable inmates—not just those with preexisting mental illness—predictably will deteriorate psychologically in prolonged isolation. Grassian, *Psychiatric Effects*, at 332; APHA, *Solitary Confinement* at 2 ("Prisoners in long-term solitary confinement are subject to significant mental suffering and deterioration."). After all, "[t]he psychological distress and suffering caused by solitary confinement" is often the reason for doing it, "not an unintended side effect." *See* Appelbaum, *Abolish Solitary*, at 410.

Inmates subjected to the profound stresses of solitary confinement exhibit a "strikingly consistent" set of "psychiatric symptoms," recorded in decades of case studies, articles, and personal accounts. Ben-

nion, *Banning the Bing* at 757; *see also* Smith, *Effects of Solitary*, at 488 ("[A] significant percentage of prisoners subjected to solitary confinement suffer from a similar range of symptoms irrespective of differences in the physical conditions in various prisons and in the treatment of isolated inmates." (collecting studies)).

Dr. Craig Haney, a preeminent expert on the psychological harms of solitary confinement, has catalogued these harms: "anxiety," "panic," "withdrawal," "hypersensitivity," "ruminations," "cognitive dysfunction," "hallucinations," "loss of control," "irritability," "aggression, and rage;" "paranoia;" "depression," "a sense of impending emotional breakdown," "self-mutilation," and "suicidal ideation and behavior." Haney, *Mental Health Issues* at 130-31 (collecting dozens of studies); *see also* Bennion, *Banning the Bing* at 757. "Even those without a prior history of mental illness" are at serious risk of developing these precise symptoms. NCCHC, *Position Statement*, at 2 (listing virtually identical symptoms).

The same catalogue of psychological disturbances is recorded in studies from several countries. Smith, *Effects of Solitary*, at 488-93 (listing dozens of studies on the prevalence of "[o]versensitivity to stimuli," a "state of confusion," "severe problems with th[e] ability to concentrate," "hallucinations," "paranoia," "violent reactions, and self-mutilation"). German studies from the nineteenth century described isolated prisoners suffering from delusions, vivid hallucinations, and psychosis. *Sourcebook*, at 10. Studies in Northern Ireland and the Soviet Union likewise have found that isolated prisoners

commonly experienced hallucinations. Lawrence E. Hinkle & Harold G. Wolff, *Communist Interrogation & Indoctrination of "Enemies of the State,"* AMA Archives of Neurology & Psychiatry, 128 (1956); T. Shallice, *The Ulster Depth Interrogation Techniques & Their Relation to Sensory Deprivation Research*, 1 Cognition 385, 390, 396 (1972). Isolated prisoners in one Norwegian study, and others, reported "perceptual distortions," hearing voices and frequent violent fantasies. Smith, *Effects of Solitary*, at 491 (citing Jan Stang et al., *Fanger i sikkerhetscelle—en utfordring.* Tidsskrift For Den Norske Lægeforening, 1844, 1846 (2003)).

Dr. Stuart Grassian, who has conducted detailed studies of what some consider the "strikingly unique" set of psychological symptoms caused by solitary confinement, has concluded that they are "suggestive of a discreet illness." Grassian, *Psychiatric Effects*, at 337. Indeed, some of the symptoms described above are found in virtually no other neuropsychiatric illness. *See id.* Dr. Hans Toch drew similar conclusions interviewing hundreds of segregated prisoners in New York, reporting that a syndrome he called "'isolation panic' was a serious problem among prisoners in solitary confinement." Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. Rev. of L. & Soc. Change 477, 518 (1997) ("Haney, *Regulating Prisons*").

Moreover, medical studies spanning decades consistently report that a troublingly high percentage of isolated inmates suffer from some or all of these characteristic psychological disturbances. The

Istanbul Statement, prepared by the International Psychological Trauma Symposium, reported that as many as 90% of isolated prisoners suffer adverse symptoms ranging from confusion to hallucinations to psychosis. Istanbul Statement at 2. Others have noted the "alarming frequency" of even the most extreme behavior in conditions of solitary confinement, like "violent reactions[] and self-mutilation." Smith, *Effects of Solitary*, at 492.

Dr. Grassian's 1983 study of isolated inmates at Walpole, Massachusetts, provides one striking record of the prevalence of psychopathology in solitary confinement. Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 Am. J. Psychiatry 1450, 1453 (1983) ("Grassian, *Psychopathological Effects*"). Half of the interviewed inmates suffered from "difficulties with thinking, concentration, and memory"—with a quarter reporting "acute confusional states." *Id.* Two-thirds exhibited "hyperresponsivity to external stimuli." *Id.* at 1452. Half had experienced "hallucinations," such as "hearing voices," and "perceptual distortions," like seeing "[t]he cell walls start wavering." *Id.* Two-thirds suffered from "massive free-floating anxiety," while nearly half experienced obsessive thoughts like "primitive aggressive fantasies" and "persecutory fears." *Id.* at 1453.

Dr. Haney consistently reported "extraordinarily high rates of symptoms of psychological trauma" in his study of segregated prisoners in a supermax facility at Pelican Bay, California. Haney, *Regulating Prisons*, at 524. More than 80% suffered from anxiety, confused thinking, obsessive thoughts, "over-sensitivity to stimuli, irrational anger, and

social withdrawal." *Id.* Over half suffered from hallucinations and perceptual distortions," "fear[ed] impending nervous breakdowns," and reported "violent fantasies" and "emotional flatness." *Id.*

A study by the Correctional Association of New York ("CANY") reported similarly high percentages of psychiatric deterioration among inmates housed in either single-cell or double-cell disciplinary lockdown. CANY, *Mental Health in the House of Corrections: A Study of Mental Health Care in New York State Prisons*, 1-2 & n.2, 54-59 (2004) ("CANY, *Mental Health*"). The researchers recounted: "On nearly every site visit, and in some lockdown units more than others, we encountered individuals in states of extreme desperation: men weeping in their cells or pacing about like caged animals; men who had smeared feces on their bodies or lit their cells on fire; prisoners who cut their own flesh in a form of self-directed violence known as self-mutilation; inmates who rambled incoherently or expressed paranoid delusions . . . ." *Id.* at 54.

The psychological harms documented in these studies are consistent with those experienced by Respondents. Bajracharya "we[pt] constantly" during his confinement, thought he was "going crazy," reported suicidal thoughts, and "scream[ed] to guards that he was going to die." Compl. ¶ 241. Benatta was so distraught over his "inexplicable, prolonged, and arbitrary confinement" that he twice attempted to injure – or possibly kill – himself by repeatedly banging his head into the walls or bars of his cell. *Id.* ¶¶ 179-82. On another occasion, he used a plastic spoon to cut himself. *Id.* ¶ 206.

The psychological trauma inflicted by solitary confinement results in extraordinarily high rates of self-harm, as compared to the general population. CANY, *Mental Health* at 58-59 (finding that 40% of isolated inmates reported self-harm). In a 2014 study of New York City jails, Dr. Homer Venters, Chief Medical Officer of New York City correctional health services, reported that "[a]lthough only 7.3% of admissions included any solitary confinement, 53.3% of acts of self-harm and 45.0% of acts of potentially fatal self-harm occurred within this group." Fatos Kaba et al., *Solitary Confinement & Risk of Self-Harm Among Jail Inmates*, 104 Am. J. of Pub. Health 442, 442 (2014). This analysis of 244,699 incarcerations revealed that exposure to solitary confinement increased the odds of experiencing self-harm by 6.89 times and potentially fatal self-harm by 6.27 times. *Id.*

The suicide rate is disproportionately high among inmates in solitary confinement as compared to the general population. Alison Liebling, *Prison Suicide & Prisoner Coping*, 26 Crime. & Just. 283, 309 (1999). Recent studies of the United States prison system report that "of all successful suicides that occur in a correctional system, *approximately fifty percent* involve the *3 to 8 percent* of prisoners who are in some form of isolated confinement at any given time." Kupers, *Isolated Confinement*, at 6 (emphasis added); *see also* Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, 13 Correctional Mental Health Rep., 1 (2011); Heriberto G. Sánchez, *Suicide Prevention in Administrative Segregation Units: What Is Missing?*, 19 J. of Correctional Health Care 93, 95 (2013).

Other countries likewise report disproportionately high suicide rates among isolated prisoners. A 2002 Danish study found that prisoners in isolation had a suicide rate *twelve times* that of the general population. Smith, *Effects of Solitary*, at 498 (citing Sigurd Benjaminsen & Birgit Erichsen, *Selvmordsadfærd Blandt Indsatte*, 16 Copenhagen: Direktoratet for kriminalforsorgen (2002)). In Finland, one third of suicides took place in isolation. Matti Joukumaa, *Prison suicide in Finland, 1969-1992*, 89 Forensic Sci. Int'l, 167 (1997). In Norway between 1956 and 1991, *three-quarters* of all prison suicides were committed by prisoners in solitary confinement, which comprised only a quarter of the prison population. Smith, *Effects of Solitary*, at 499-500. A German study of Bavarian prisons between 1945 and 1974 concurs that prison suicide most commonly occurred "in solitary confinement." W Spann et al., *Suizide in bayrischen Vollzugsanstalten,* Münchener medizinische Wochenschrift, 315-16 (1979).

Finally, medical research shows that even after inmates are eventually released from prolonged solitary confinement, they may continue to suffer psychological damage "severe enough to cause near permanent mental and emotional damage." Elizabeth Vasiliades, *Solitary Confinement & Int'l Human Rights: Why the U.S. Prison System Fails Global Standards*, 21 Am. U. Int'l L. Rev. 71, 76-77 (2005). Due to long-lasting psychological effects, some prisoners held in solitary confinement have serious difficulty returning to society (or even to the general prison population). *See* Ida E. Koch, *Isolationens psykiske og sociale følgevirkninger*, 60 Månedsskrift for Praktisk Lægegerning, 382 (1982) ("Koch, *Isola-*

tionens")) (reporting that post-isolation prisoners in Denmark experienced enormous anxiety around other people, to the degree that some voluntarily prolonged their isolation).

The "lasting mental health implications" of pathologies developed in prolonged isolation include the inability to initiate or control behavior or interact with other people, loss of one's sense of self and control over emotions, and withdrawal into a fantasy world. Haney, *Mental Health Issues* at 138-41. Because prolonged solitary confinement transforms inmates' personalities, they subsequently grapple with an altered self-image on a daily basis, as well as overwhelming feelings of inadequacy, "invalidating stigmas, relived abuse, uncontrollable paranoia or anxiety, self-imposed seclusion, [and] difficulties with sexual intimacy." Joane Martel, *Solitude & Cold Storage: Women's Journeys of Endurance in Segregation*, Elizabeth Fry Soc'y of Edmonton, 87 (1999). One Canadian study found that over 50% of formerly isolated prisoners experienced at least some of these long-term psychological impairments. *Id.* at 85-86. "Those who are not blessed with special personal resiliency and significant social and professional support needed to recover from such atypical and traumatic experiences may never return to the free world and resume normal, healthy, productive social lives." Haney, *Mental Health Issues* at 141.

Similarly, the Respondents in this case "continue[] to suffer" the "emotional and psychological effects of [their] detention" long after their release. Compl. ¶¶ 154, 171, 193, 228. Several have trouble with concentrating, communicating, trusting others, sleeping, studying, and finding work and some have

lost their homes, businesses, or jobs. *Id.* ¶¶ 171, 193, 213, 228, 244. Respondents now face numerous long-term and potentially permanent mental health issues, including post-traumatic stress disorder, depression, anger, isolation, fear of travel, difficulties handling open areas or light, and an inability to enjoy life. *Id.* ¶¶ 193, 213, 228, 244. The medical literature resoundingly confirms that Respondents' experience of this long-term psychological damage directly resulted from their prolonged solitary confinement.

B. Research Additionally Demonstrates that Solitary Confinement Causes Serious Physiological Damage

The deleterious health effects of solitary confinement are not only psychological. Experts have found numerous "corresponding physiological consequences" among inmates subjected to solitary confinement. Carnagie Fujio et al., Physicians for Human Rights, *Buried Alive: Solitary Confinement in the U.S. Detention System*, 1-2 (April 2013) ("*Buried Alive*").

The physiological damage caused by isolation has been documented by researchers in numerous countries since the nineteenth century. *Id.* For example, in Denmark in the 1860s, shortly after the new Vridsløselille Penitentiary opened, "it became apparent that serious health problems had arisen" among prisoners held in isolation there. Smith, *Effects of Solitary*, at 461-62; Peter Scharff Smith, *Isolation & Mental Illness in Vridsløselille 1859-1873: A New Perspective on the Breakthrough of the*

Modern Penitentiary, Scandinavian J. of Hist., 4-9, 12-13, 15-16, 29 (2004). Even though the prisoners "were typically described as healthy upon their entrance to the prison," "at least a third of the inmates reacted to isolation with adverse health effects," including a "total lack of energy" and "physical laxity." Smith, *Effects of Solitary*, at 461-62. German studies from the nineteenth century likewise reported severe health effects among isolated prisoners. *Id.* at 466 (recounting a German prisoner's description of "how absolute isolation had 'a very injurious effect on the body and mind'").

Medical experts have confirmed that physiological harms "can occur after only a few days in solitary confinement and the health risks rise with each additional day spent in such conditions." Expert Rep. of Juan E. Méndez, at ¶¶ 56, 62, *Ashker v. Governor of the State of Cal.*, No. 09-cv-5796 (N.D. Cal. Mar. 6, 2015) ("Méndez Expert Report") (citing Istanbul Statement). The litany of physiological symptoms associated with solitary confinement, even for a short period of time, include insomnia, headaches, lethargy, dizziness, heart palpitations, appetite loss, weight loss, severe digestive problems, diaphoresis (*i.e.*, profuse sweating), back pain, joint pain, deteriorated vision, shaking, chills, and aggravation of preexisting medical problems. *Buried Alive* at 1-2; *see also* Grassian, *Psychopathological Effects*, at 1450 (reporting that isolated prisoners in the 1983 Walpole study suffered from numerous physical symptoms, including gastrointestinal, cardiovascular, and genitourinary problems, migraine headaches, and profound fatigue).

The same collection of physiological symptoms has been reported throughout medical studies in many countries. Sharon Shalev, a human rights advocate and criminologist in the United Kingdom, has found that isolated inmates consistently report symptoms nearly identical to those recorded by American researchers. *Sourcebook*, at 15. Several Canadian studies of isolated prisoners confirm these same physiological symptoms, as well as others like pains in the abdomen, pains and pressure in the chest, and fainting. *See, e.g.*, Michael Jackson, *Prisoners of Isolation: Solitary Confinement in Canada*, 67 (1983). The World Health Organization ("WHO") lists a virtually identical group of serious physiological symptoms resulting from solitary confinement. Stefan Enggist et al., WHO Regional Office for Europe, *Prisons & Health*, 28 (2014) ("WHO, *Prisons & Health*") (listing "gastrointestinal and genitourinary problems; diaphoresis; insomnia; deterioration of eyesight; lethargy, weakness, [and] profound fatigue; feeling cold, heart palpitations; migraine headaches; back and other joint pains; poor appetite, weight loss, diarrhea; tremulousness; [and] aggravation of preexisting medical problems").

These characteristic physiological symptoms are highly prevalent among inmates, including previously healthy individuals, held in isolation. *See* Méndez Expert Report, at ¶ 56 ("a significant number of individuals [in isolation] will experience serious health problems regardless of the specific conditions, regardless of time and place, and regardless of preexisting personal factors.") (quoting Istanbul Statement). Dr. Haney's 1993 Pelican Bay study, for example, revealed that more than 80% suffered from

headaches, lethargy, and troubled sleep. Haney, *Mental Health Issues* at 133. Over 50% experienced loss of appetite, dizziness, nightmares, heart palpitations, and perspiring hands. *Id.* Dr. Haney has likened the constellation of physical symptoms of solitary confinement to those of hypertension. *Id.*

Other studies in the United States and elsewhere confirm the high prevalence of physiological damage among prisoners held in long-term solitary confinement. In Dr. Haney's 2013 re-interview of prisoners from the Pelican Bay study, 100% suffered from headaches, lethargy, troubled sleep, and dizziness, while over 70% still reported nightmares, heart palpitations, and perspiring hands. Expert Rep. of Craig Haney, at 62, 84, *Ashker v. Governor of the State of Cal.*,, No. 09-cv-5796 (N.D. Cal. Mar. 12, 2015). A 2014 North Carolina study similarly reported that, out of 51 prisoners interviewed, 41 suffered headaches; 38 had problems sleeping; 19 had heart palpitations; 24 experienced dizziness; and 25 experienced appetite and weight loss. Mark Bowers et al., *Solitary Confinement as Torture*, U. of N.C. Sch. of L. Immigration/Human Rights Clinic, 69 (2014). A Danish study concluded that *nearly all* isolated prisoners "suffer after days or a few weeks of nervous symptoms" including "lack of ability to sleep" and "psychosomatic symptoms." Smith, *Effects of Solitary*, at 484 (citing Koch, *Isolationens*, at 382).

These physiological symptoms directly result from the inherent characteristics of solitary confinement. For example, Dr. Kupers observed the negative effects of the absence of natural light in solitary

confinement in a 2014 study at the Eastern Mississippi Correctional Facility. Expert Rep. of Terry A. Kupers, E. Miss. Correctional Facility, at 17 (June 16, 2014), https://www.aclu.org/sites/default/files/assets/expert_report_of_terrry_kupers_with_table_of_contents.pdf. As Dr. Kupers explained, inmates held in solitary may lose normal diurnal rhythm—the steady alteration of day and night—after inadequate exposure to natural light. *Id.* Because diurnal rhythm orients a person in time and enables fundamental biological processes of the body, its loss causes significant sleep deprivation, with attendant physiological and psychological deterioration. *See id.*[5]

In this case, the Respondents endured constant artificial lighting and could not even manufacture darkness by covering their faces. Compl. ¶ 119. They were deprived of meaningful access to the outdoors for exercise or natural light. *See, e.g., id.* ¶¶ 122-27, 178. All of the Respondents were deprived of sleep—some for days on end. *Id.* ¶¶ 121, 181, 206. This persistent lack of sleep caused "substantial physical and emotional distress." *Id.* at ¶ 121. It was after a bout of sleepless nights, for example, that Benatta "snapped" and began banging his head against the bars of his cell. *See id.* ¶¶ 181-82, 206. He does not remember "what he was think-

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[5] Sleep deprivation "greatly exacerbates the tendency to suffer psychiatric breakdown and become suicidal[;]" "creates fatigue[,] and magnifies cognitive problems, memory deficits, confusion, anxiety, and sluggishness." Kupers Expert Report, at 17.

ing, or whether he was trying to kill himself." *Id.* 182.

Many studies also show that sensory deprivation during solitary confinement has corrosive effects on brain functioning. *Sourcebook*, at 19-20. Researchers have used electroencephalograms ("EEGs"), which record electrical activity in the brain, to study isolated prisoners' brain waves. Grassian, *Psychiatric Effects*, at 330-31. These tests reveal that "even a few days of solitary confinement will predictably shift the [EEG] pattern toward an abnormal pattern characteristic of stupor and delirium." *Id.* Canadian studies recorded similar results among isolated prisoners, who exhibited a "slowing of EEG [and] alpha frequency." G.D. Scott et al., *Changes in EEG Alpha Frequency & Evoked Response Latency During Solitary Confinement*, 79 J. of Abnormal Psych., 54, 54 (1972). Lethargic conditions have been described by researchers in connection with "a complete breakdown or disintegration of the identity of the isolated individual." Smith, *Effects of Solitary*, at 492.

Further, studies strongly suggest that solitary confinement can fundamentally alter the structure of the human brain in profound and permanent ways.[6]

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[6] While direct studies of the impact of solitary confinement on prisoners' brains have not been possible due to experimental challenges, evidence from human and animal studies inform an understanding of the brain mechanisms that underlie the observed symptoms in prisoners who have been isolated for protracted periods. *See* ACLU, *Briefing Paper: The Dangerous Overuse of Solitary Confinement in the United States*, 6 (Aug. 2014),

Dr. Huda Akil, a neuroscientist and specialist in the effects of emotions and stress on brain structure and function, reports that *each* key characteristic of solitary confinement—lack of physical activity, meaningful interaction with others and the natural world, and visual stimulation—"is by itself sufficient to change the brain . . . dramatically, depending on whether it lasts briefly or is extended," even just for days. Kate Allen, *Researchers Study Effects of Prolonged Isolation Among Prisoners*, The Toronto Star (Feb. 14, 2014), https://www.thestar.com/news/world/2014/02/14/researchers_study_effects_of_prolonged_isolation_among_prisoners.html.

Dr. Akil has summarized many neurobiological studies that reveal that certain regions of the brain of people who experience extreme psychological stress (like those in solitary confinement) literally diminish in volume because the neural cells become shriveled. *See* ACLU, *Briefing Paper*, at 6. Dr. Akil's research aligns with decades of experimental studies on mammals demonstrating the neurological harms of isolation and sensory deprivation. ACLU, *Briefing Paper*, at 6. For example, a study at the University of California-Berkeley showed that rats in supermax-style cells had fewer neurological connections and thinner cerebral cortexes—the brain's "grey matter" that controls perception, language, planning, movement, and social cues. *Id.*

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https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf ("ACLU, *Briefing Paper*").

This neurological damage, and other physiological harms inflicted by solitary confinement can be long-lasting, even permanent. Several studies conclude that the decline in brain activity that occurs in solitary confinement, as confirmed by EEGs, can be irreversible if isolation is prolonged, as it was in this case. *Sourcebook*, at 20; *see also* Grassian, *Psychiatric Effects*, at 325. Various international bodies have stressed that "all forms of solitary confinement without appropriate mental or physical stimulation are likely in the long term to have damaging effects." European Committee for the Prevention of Torture & Inhuman or Degrading Treatment or Punishment, *Rep. to the Gov't of Denmark on the visit to Denmark carried out by the CPT, from Jan. 28–Feb. 4, 2002*, 20 (Sept. 25, 2002), http://www.cpt.coe.int/documents/dnk/2002-18-inf-eng.pdf; *see also* WHO, *Prisons & Health*, at 31.

In sum, notwithstanding the pervasive use of solitary confinement in the United States, the consensus among experts is that solitary confinement, as imposed on Respondents in this case, inflicts serious and often long-lasting physiological harm.

II. International Legal Standards and the Laws of Other Countries Prohibit the Imposition of Solitary Confinement Under the Circumstances of This Case

International law has long prohibited the cruel and inhuman treatment of prisoners, including in the 1948 United Nations ("U.N.") Universal Declaration of Human Rights, G.A. Res. 217A(III) (Dec. 10, 1948) ("UDHR"); the 1976 U.N. International Covenant on Civil and Political Rights, G.A. Res.

2200A(XXI) (Mar. 23, 1976) ("ICCPR"); and the 1984 U.N. Convention Against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46 (Dec. 10, 1984) ("CAT"). Moreover, international bodies recognize that solitary confinement qualifies as cruel and inhuman treatment unless applied in strictly limited circumstances and for a strictly limited duration. The Mandela Rules, as well as the Office of the High Commissioner for Human Rights ("OHCHR") Manual on the Effective Investigation & Documentation of Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment (1999) ("Istanbul Protocol"), embody the recent iterations of these well-settled international law principles. These standards for the use of solitary confinement likewise are reflected in the laws of many countries.

Under such standards, the use of solitary confinement was impermissible in this case because it was (i) based on religion or race, (ii) based on the pretext of immigration violations, and (iii) used as a measure of first, not last, resort. Moreover, even if the use of solitary confinement had been justified—which it was not—the indefinite, prolonged duration and extreme conditions endured by Respondents likewise violated international laws.

Since World War II, international conventions have prohibited cruel and inhuman treatment, as well as torture. In 1948, the UDHR dictated that "[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment." UDHR art. 5. The 1976 ICCPR and the CAT—to which the United States is a party—contain identical prohibitions. *See*

ICCPR art. 7; CAT art. 2 ("Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.").

"Torture" and "cruel and inhuman treatment" both refer to "the infliction of 'severe physical or mental pain or suffering.'" Int'l Comm. of Red Cross, *Customary IHL - Rule 90, Torture & Cruel, Inhuman or Degrading Treatment*, 1, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule90. Torture, however, additionally, is inflicted or justified for "a specific purpose," like "obtaining . . . information or a confession" or "any reason based on discrimination of any kind." *Id.* at 2; CAT art. 1. Both of those purposes motivated the imposition of solitary confinement in this case. Compl. ¶¶ 1, 61, 77.

Human rights bodies applying these international laws "have found violations of the prohibition of inhuman treatment" in cases of solitary confinement, particularly when prolonged and extreme, as occurred in this case. *Customary IHL - Rule 90* at 2. For example, the Inter-American Court of Human Rights ("IACHR") held that "prolonged isolation and deprivation of communications are in themselves cruel and inhuman treatment" because they are "harmful to the psychological and moral integrity of [a] person" and violate "inherent dignity as a human being." *Velasquez-Rodriguez v. Honduras*, Inter-Am.

Ct. H.R. (ser. C), No. 4, ¶ 156 (July 29, 1988). The European Court of Human Rights has found that "complete sensory isolation, coupled with total social isolation, can destroy the personality" and thus "constitutes a form of inhuman treatment" in violation of international law. *Ilaşcu v. Moldova & Russia*, Application No. 48787/99, Eur. Ct. of H.R. (2004).

The international prohibition on extreme, prolonged solitary confinement was restated most recently in the U.N.'s 2015 Mandela Rules. These "minimum standards" for "detention of prisoners" require that "all prisoners shall be protected from[] torture and other cruel, inhuman or degrading treatment or punishment, *for which no circumstances whatsoever may be invoked as a justification.*" Mandela Rules at 1 (emphasis added). The Mandela Rules squarely prohibit "solitary confinement" as "amount[ing] to torture or other cruel, inhuman or degrading treatment or punishment"—unless imposed under strictly limited circumstances. *Id.* at 43.

Under these international standards, Respondents' placement in solitary confinement for *any* duration was illegal, first because solitary confinement cannot be imposed based on race or religion. In 1969, the International Convention on the Elimination of All Forms of Racial Discrimination "condemn[ed] racial discrimination" and guaranteed "[t]he right to equal treatment before the tribunals and all other organs administering justice." *See* G.A. Res. 2106, Int'l Convention on the Elimination of All Forms of Racial Discrimination, art. 2(1), 5(a) (Jan. 4, 1969). The U.N.'s prior version of the Standard

Minimum Rules for the Treatment of Prisoners in place in 2001-2002, required that standards for incarceration "be applied impartially." U.N. Congress on the Prevention of Crime & the Treatment of Offenders, Standard Minimum Rules for the Treatment of Prisoners at 6 (May 13, 1977) ("1977 U.N. Rules"). Thus, "[t]here shall be no discrimination on grounds of race, . . . religion . . . national or social origin, . . . or other status." *Id.* This rule applied equally to "all categories of prisoners, criminal or civil, untried or convicted, including prisoners subject to 'security measures' . . . ." 1977 U.N. Rules at 4(1). The current Mandela Rules likewise dictate that "[t]here shall be no discrimination" in the application of prison standards "on the grounds of race, . . . religion, . . . [or] national or social origin." Mandela Rules at 2.

Consistent with this international legal standard, many other countries prohibit the discriminatory treatment of prisoners based on their religion or race. *See, e.g.*, Law No. 24.660, July 8, 1996 (*Ley de Ejecución de la Pena Privativa de la Libertad n° 24.660*), Argentina (requiring that rules governing prison sentences be applied without discrimination based on race, religion, or other circumstances); Fundamental Law of Hungary (2011), art. XV(2) (guaranteeing fundamental rights, including to Hungarian prisoners, without discrimination based on race or religion); Canadian Charter of Rights & Freedoms, Part I of the Constitution Act, 1982 § 15 (providing equal protection and banning religious discrimination); Racial Discrimination Act 1975 (CTH) s 10, Australia (providing people of any "race, colour or national or ethnic origin" the right to

equality before the law); *Jones v Scully* (2002) 120 FCR 243, [111-113] (holding that ethno-religious groups, such as Muslims, constitute protected groups under the Racial Discrimination Act); *Naen v Minister for Immigration & Multicultural & Indigenous Affairs* [2003] FCA 216, [72] (same).

Yet, here, the Respondents were placed in isolated confinement precisely because of their religion and faced religious discrimination throughout detention. Respondents were routinely physically and verbally accosted for being Muslim, and were consistently deprived of the ability to observe their faith. *See* Compl. ¶¶ 66, 103, 109, 117, 131-39. For example, the Respondents were denied access to the Koran, religiously appropriate food, and the means to maintain their daily prayer requirements. *Id.* ¶¶ 128, 132-39, 261. Indeed, the Respondents were often punished for praying. For instance, one received an incident report for refusing to stand up for count during prayer, while others were unable to obtain razors or hygienic supplies (which guards purposely passed out during prayer times). *Id.* ¶¶ 135, 138.

International law further articulates that discriminatory treatment will not be excused even in a time of national emergency, like September 11th. The ICCPR, which prohibits inhuman treatment, provides that "[i]n time of public emergency" a state may "derogate[e] [its] obligations under the present Covenant to the extent strictly required by the exigencies of the situation, *provided that such measures . . . do not involve discrimination solely on*

the ground of race, . . . religion or social origin."[7] ICCPR art. 4(1) (emphasis added); *accord* U.N. Human Rights Comm., General Comment No. 29, States of Emergency (Article 4) ¶ 8 U.N. Doc. No. CCPR/C/21/Rev.1/Add.11 (Aug. 31, 2001).

Additionally, while the government in this case used the pretext of immigration violations to detain Respondents, international legal standards forbid the imposition of solitary confinement on *that* basis as well. "[I]mmigration detention, and conditions and treatment of detained migrants, [must] comply with international human rights law." U.N. OHCHR Opening Remarks on "Human Rights of Migrants in Detention Centres," 12th Sess., H.R. Council (Sept. 19, 2009). Under international human rights law, "[administrative] detention of migrants on the grounds of their irregular status should under no circumstances be of a punitive nature." Francois Crépeau, Rep. of Special Rapporteur on Human Rights of Migrants ¶ 31, U.N. Doc. A/HRC/20/24 (Apr. 2, 2012). Thus, immigrants in detention "should not be subject" to "highly restricted movement, lack of outdoor recreation and lack of contact visitation"—all of which occurred in the extreme solitary confinement at issue here. *Id.* The U.N.'s principles on arbitrary detention similarly require that a detained immigrant "must have the possibility, while in custody, of communicating with the outside world" and "must be informed of . . . any

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[7] In accordance with this international principle, China forbids discrimination based on religion or territory even in cases involving terrorism. Anti-Terrorism Law of People's Republic of China, art. 6 (2016).

possibility of his or her being held incommunicado, as well as of the guarantees accompanying such a measure." OHCHR, Rep. of the Working Grp. on Arbitrary Detention, Civ. & Pol. Rights, Annex II, Principles 1-5, U.N. Doc. E/CN.4/2000/4 (Dec. 28, 1999). The placement of detained immigrants into solitary confinement violates these principles.[8]

The OHCHR recently reiterated that international law prohibits prolonged solitary confinement for immigrant detainees, even if based on suspicion of terrorism. "'[T]he use of 'administrative detention' under public security legislation [or] *migration laws* . . . resulting in [the] deprivation of liberty for unlimited time or for very long periods without effective judicial oversight, as a means to detain persons suspected of involvement in terrorism or other crimes, is *not* compatible with international human rights law." OHCHR, Compilation of Deliberations of Working Grp. On Arbitrary Detention, Delib. No. 9, ¶ 73, U.N. Doc. No. A/HRC/22/44 (Dec. 24, 2012). The OHCHR observed that such "administrative detention is particularly worrying as it

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[8] Consistent with these international legal principles, Argentina forbids the use of solitary confinement as punishment for violations of immigration laws. Law No. 25.871, Jan. 20, 2004 (*Ley de Ejecución de la Pena Privativa de la Libertad* N° 25.8714), art. 82 & L. N° 25.871, art. 70, Argentina. Recognizing that immigration detention should not be punitive, England and Wales prohibit "special accommodation" (*i.e.*, solitary confinement) for punishment, except as a "temporar[y]" measure for as long as a detainee is "refractory or violent." The Detention Centre Rules, 2001 SI 2001/238, Rule 42(1), England and Wales ("Detention Centre Rules").

increases the likelihood of solitary confinement, acts of torture and other forms of ill-treatment"—precisely what occurred in this case.[9] *Id.*

Additionally, the imposition of solitary confinement was unlawful in this case because it was used as a measure of first resort. International law requires that solitary confinement be used only "as a last resort." Mandela Rules at 45(1). In other words, solitary confinement "shall not be imposed by virtue of a prisoner's sentence" in the first instance. *Id.*; *see also* G.A. Res. 45/111, Principle 7 (Dec. 14, 1990). Instead, international law contemplates the limited use of "[p]unishment by close confinement" solely as a "disciplin[ary]" measure for prisoners who break prison rules. 1977 U.N. Rules at 32(1).

Many countries apply this same "last resort" principle by refusing to impose solitary confinement as part of an initial sentence and permitting it solely based on some *additional*, enumerated factor arising after the individual is detained. *See, e.g.*, Detention Centre Rules, at 40, 42 (imposing isolation only to control violent behavior or in interest of security or safety); Prison Act of 16 March 1976, amended by

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[9] Indeed, the Istanbul Protocol specifically includes among its "list of torture methods" solitary confinement and the accompanying conditions that were imposed in this case, such as "a small or overcrowded cell . . ., exposure to extremes of temperature, denial of privacy . . . [d]eprivation of normal sensory stimulation . . ., abuse of physiological needs, restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care, social contacts . . . [and] loss of contact with the outside world." Istanbul Protocol ¶ 145(m)-(n) (2004).

art. 7, Act of 25.04.2013 §§ 88-89, Germany (allowing isolation based on additional factors such as prisoner's behavior, mental state, danger of escape or violent attack, or danger of suicide or self-harm); Australian Human Rights Commission, *Human rights standards for immigration detention,* § 3.7 (2013) ("Australian Human Rights Standards") (same); Ordinance for Treatment of Detainees, art. 18 (1981), Japan (same); Imprisonment Act (767/2005), "Vankeuslaki" ("Finland Imprisonment Act") Ch. 18, Finland (permitting isolation only to prevent harm to prisoner or others, escape, drug use, drug-related offenses, or similar situations); Prison Rules 2007 (SI252/2007), Rules 62-64, Ireland (basing isolation on factors such as whether individual is at "imminent" risk of harming himself); Irish Prison Act (2007), part 3 (allowing isolation for violating prison disciplinary code); Anhalteordnung Detention Regulation [BGBl. II Nr.] No. 128/1999, as amended, BGBl. II Nr. 439/2005, § 5, Austria (basing solitary confinement on factors such as violence against other inmates, risk of infection, or disruption); *Ogiamien v. Ontario*, 2016 ONSC 3080 (Canada); *R. v. Hamm*, 2016 ABQB 440 (Canada) (finding segregation illegal when lacking rational explanation or where penitentiary did not establish absence of viable alternative); *Bacon v. Surrey Pretrial Services Centre*, 2010 BCSC 805 (Canada) (same); *Grenier v. R.*, 2004 FC 132 (same); *Circulaire du 14 avril 2011 relative au placement à l'isolement des personnes détenues* NOR: JUSK1140023C, France (allowing isolation only when impossible to otherwise protect detainees or facility); Australian Human Rights Standards § 3.7 (providing for isolation as a last resort and where necessary to avoid serious and imminent

threat of self-harm, injury, or destruction of property).

Furthermore, the immediate use of isolation was particularly troubling in this case because Respondents had not been convicted or even charged with a crime. International law recognizes that "[s]olitary confinement of unconvicted individuals . . . is potentially harmful" because it can "coerce the detainees and force them to self-incriminate or to provide any type of information." Inter-American Commission on Human Rights, Rep. on the Use of Pretrial Detention in the Americas, Doc. 46/13, OEA/Ser.L/V/II., ¶ 280, (2013); *see also* Méndez 2011 Report ¶ 73 ("When solitary confinement is used intentionally during pretrial detention as a technique for the purpose of obtaining information or a confession, it amounts to torture . . . or to cruel, inhuman, or degrading treatment").[10]

Even if the use of solitary confinement could have been justified in this case, its duration was unjustifiable and violated international legal standards. International law prohibits "[i]ndefinite" and

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[10] *See also Essex paper 3: Initial guidance on the interpretation & implementation of the Nelson Mandela Rules, Ch. 5. Restrictions, discipline & sanctions*, U. of Essex-Human Rights Centre, at 13 (Apr. 2016) (solitary confinement may not be used "intentionally for purposes such as punishment, intimidation, coercion or obtaining information or a confession, or for any reason based on discrimination" (quoting Juan E. Méndez, Interim Report of the Special Rapporteur on Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶ 60, U.N. Doc. A/68/295 (Oct. 7, 2013))).

"[p]rolonged" solitary confinement as "amount[ing] to torture or other cruel, inhuman, or degrading treatment or punishment." Mandela Rules at 43. As explained by the Special Rapporteur, "[t]he feeling of uncertainty when not informed of the length of solitary confinement exacerbates the pain and suffering of the individuals who are subjected to it." Méndez 2011 Report ¶ 59. And, "the longer the duration of solitary confinement . . . the greater the risk of serious and irreparable harm." *Id.* ¶ 58. International law defines prolonged solitary confinement as "a time period in excess of 15 consecutive days," a limit far exceeded in this case. Mandela Rules at 44.[11]

The extreme isolation and sensory deprivation imposed on Respondents likewise violated international standards for the conditions of solitary confinement. International law forbids placement in a

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[11] Similarly recognizing the pain and suffering inflicted by prolonged solitary confinement, many countries limit its duration to relatively short time periods. *See, e.g.*, Detention Centre Rules, at Rule 40(3) (capping isolation for immigration detainees at 24 hours, with extension to three days, upon authorization from Secretary of State); Finland Imprisonment Act, Ch. 15 § 8 (10-day cap, after which prisoner cannot be isolated again for seven days); Correctional Services Act 1982 (SA) s 36(3), Australia (30-day cap); Prisons Act 1981 (WA) s 43(1) (same); Corrective Services Act 2006 (QLD) s 53(2) (same); Corrections Management Act 2007 (ACT) s 90(8) (same); Law of the People's Republic of China on Administration of Embarkation and Disembarkation, arts. 59-60 (2013) (30-day cap, with extension to a maximum of 60 days upon additional approval).

"constantly lit cell," as occurred in this case, as "inhuman" treatment. Mandela Rules at 43(1). Moreover, under the 1977 U.N. Rules in place in 2001-2002, prisoners must be allowed regular communication with family and "reasonable facilities to communicate with the diplomatic and consular representatives of [their] State." 1977 U.N. Rules at 37-38(1); Mandela Rules at 62. "[U]ntried prisoner[s]" must be allowed "visits from [] legal adviser[s]." 1977 U.N. Rules at 93; Mandela Rules at 61(a).[12] Thus, the complete social isolation and communications blackout used in this case likewise was in violation of international law.

CONCLUSION

For the foregoing reasons, and the reasons set forth in Respondents' brief and in the other *amicus* briefs filed in support of Respondents, Amici respectfully submit that this Court affirm the Second Circuit's decision and permit Respondents to litigate their constitutional challenges to the punitive treatment they suffered in solitary confinement.

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[12] Other countries similarly regulate the conditions of solitary confinement to moderate the degree of social isolation and sensory deprivation. *See, e.g.*, Finland Imprisonment Act, Ch. 15 § 8 (permitting inmates in isolation to keep their possessions and receive visitors); *Id.* at Ch. 11, § 3 (guaranteeing Finnish prisoners the right to religious observance); Corrective Services Regulation 2006 (QLD) § 5, Australia (guaranteeing isolated prisoners access to personal items, appropriate clothing, and reticulated water, and exercise in fresh air).

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APPENDIX

APPENDIX A

Amici curiae are the following nineteen individuals:

1. Huda Akil, Ph.D., is a Gardner Quarton Distinguished University Professor of Neuroscience and Psychiatry and Co-Director and Senior Research Professor of the Molecular and Behavioral Neuroscience Institute at the University of Michigan. Research in Dr. Akil's laboratory is focused on understanding the neurobiology of emotions, including pain, anxiety, and depression. Dr. Akil also served as a past President of the Society for Neuroscience, the largest neuroscience organization in the world, and has been elected a member of the National Academy of Sciences.

2. Scott Allen, M.D., F.A.C.P., is a Professor of Medicine and Vice Chair of the Clinical Division at the University of California, Riverside. He also is the co-founder and co-director of the Center for Prisoner Health and Human Rights at The Miriam Hospital. He serves as medical advisor to Physicians for Human Rights ("PHR") on its work to stop torture and was lead medical author of PHR's reports "Experiments in Torture," "Aiding Torture," and "Leave No Marks." He served seven years as a full-time physician for the Rhode Island Department of Corrections, acting as the department's medical program supervisor between 2001 and 2004.

3. Bradley Brockmann, Esq. is the Executive Director for the Center for Prisoner Health and Human Rights at The Miriam Hospital. The Center is affiliated with Brown University and raises

awareness at the national and state level about healthcare issues and other justice-involved populations. He designs and teaches courses focused on Prisoner Health at the School of Public Health at Brown University. Mr. Brockman also worked as a civil rights attorney with Prisoners' Legal Services of Massachusetts.

4. Robert L. Cohen, M.D., is a clinical instructor at the New York University School of Medicine. He has been appointed numerous times by federal courts and the Department of Justice to monitor health care in U.S. prisons. Dr. Cohen's recent presentations address the impact of solitary confinement on prisoner health, the health care of detained immigrants, and protection of the civil rights of detained persons.

5. Stefan Enggist is a Senior Project Manager in Switzerland's Federal Office of Public Health. Previously, he was the Technical Officer of Health in Prisons at the World Health Organization's Regional Office for Europe in Copenhagen, Denmark.

6. Joe Goldenson, M.D., is a physician who served as the Director and Medical Director for Jail Health Services for the San Francisco Department of Public Health for twenty-eight years. Dr. Goldenson also served as Assistant Clinical Professor at the University of California, San Francisco from 1980 to 2015, and has worked extensively as a correctional health medical expert and court monitor of inmate medical care in U.S. jails. He also served as a medical expert and monitor retained by federal district courts in various cases. Mr. Goldenson is the Ameri-

can Public Health Association's representative to the Board of the National Commission on Correctional Health Care ("NCCHC").

7. Stuart Grassian, M.D., is a psychiatrist who taught at Harvard Medical School for almost thirty years. He has numerous publications and extensive experience evaluating the psychiatric effects of stringent conditions of confinement, including the psychiatric syndrome resulting from deprivation of social, perceptual, and occupational stimulation in solitary confinement.

8. Craig Haney, Ph.D., is a social psychologist and Distinguished Professor of Psychology at the University of California, Santa Cruz ("UCSC"). Dr. Haney is also the Director of the program in Legal Studies at UCSC and the UCSC Presidential Chair. Dr. Haney is noted for his numerous publications, including five books, and his work on the study of the psychological impact of solitary confinement and prison isolation. Dr. Haney has served as an expert witness in several federal court cases related to the prison environment and punishment, and he has testified before the Subcommittee on the Constitution, Civil Rights and Human Rights of the U.S. Senate Judiciary Committee.

9. Terry A. Kupers, M.D., is a Professor at the Wright Institute and psychiatrist with a background in psychoanalytic psychotherapy, forensics and social and community psychiatry. He has provided expert testimony in several large class action litigations concerning jail and prison conditions, and he provides consultation and staff training on the psychological effects of prison conditions, including

solitary confinement. Mr. Kupers has published several books and articles and is a consultant to Human Rights Watch.

10. Shane O'Mara is Professor of Experimental Brain Research at Trinity College, Dublin (Personal Chair), and Principal Investigator and Director of the Trinity College Institute of Neuroscience. He has published more than 110 peer-reviewed papers, including on brain systems affected by stress, anxiety, depression, and motivation, and wrote the book *Why Torture Doesn't Work: The Neuroscience of Interrogation.*

11. Hernán Reyes, M.D., is a Senior Research Fellow at the Human Rights Center at the University of California, Berkeley. He is also the former medical coordinator for Health in Prisons for the International Committee of the Red Cross ("ICRC"), a post he occupied from 1984-2012. Dr. Reyes documented prison health, as well as ill-treatment, human rights violations, and torture for the ICRC in more than 45 countries around the world during his 28 years with ICRC. Since 1991, he has been medical Observer for the ICRC to the World Medical Association ("WMA") and its Ethics Committee, working closely with the WMA on many ethical issues of concern in prisons.

12. Josiah D. Rich, M.D., M.P.H., is a Professor of Medicine and Epidemiology at the Warren Alpert Medical School of Brown University. He also is a practicing Infectious Disease Specialist at the Rhode Island Department of Corrections. Dr. Rich has written close to 190 peer-reviewed publications, predominantly concerning the overlap between

infectious diseases, addictions, and incarceration. He is the Director and co-founder of the Center for Prisoner Health and Human Rights and also is a Co-Founder of the Centers for AIDS Research's nationwide initiative on collaboration in HIV in corrections.

13. Barry H. Roth, M.D. is a forensic psychiatrist who has performed forensic torture survivor evaluations for twenty years. Mr. Roth is a member of Physicians for Human Rights; Program in Psychiatry and Law, Harvard Medical School; World Psychiatric Association Section on Psychological Consequences of Torture & Persecution; and the International Forum of Teachers of the UNESCO Chair in Bioethics. Mr. Roth is a Distinguished Life Fellow of the American Psychiatric Association and Massachusetts Psychiatric Society. He also is an instructor of the Harvard Law School Trial Advocacy Workshop and former Harvard Medical School instructor.

14. Pau Perez-Sales, M.D., a psychiatrist, is the Chair of the Section on Psychological Consequences of Persecution and Torture of the World Psychiatric Association. He is the founder of a number of groups dedicated to addressing the medical care of victims of torture and has served as an independent consultant and forensic expert in national and international courts for victims of abuse and torture. Dr. Perez-Sales was also the founding member and president of the Human Rights Section of the Spanish Association of Neuropsychiatry and is an elected member of the Board of the International Society for Health and Human Rights ("ISHHR") and the Section on Torture of the World Psychiatric Association ("WPA").

15. Peter Scharff Smith, Ph.D., is an Associate Professor in the Department of Criminology and Sociology of Law at the University of Oslo. He also is a Professor in Criminology in the Department of Sociology and Social Work at Aalborg University. He has numerous publications concerning the use and effects of solitary confinement on prison inmates.

16. Pablo Stewart, M.D., is a Clinical Professor of Psychiatry at the University of California, San Francisco School of Medicine. He has over thirty years of experience working in the criminal justice system, including serving for ten years as a federal-court-appointed psychiatric expert on the effects of solitary confinement on the mental health of inmates.

17. Nora Sveaass, Ph.D., is a psychologist and Associate Professor at the Department of Psychology at the University of Oslo. Her research, publications, and professional experience have focused on human rights violations, the psychological consequences of torture and violence, and the treatment and rehabilitation of victims of torture and violence. Dr. Sveaass served two terms on the United Nations Committee against Torture from 2005 to 2013 and is currently a member of the United Nations Subcommittee for the Prevention of Torture.

18. Homer D. Venters, M.D., is the Chief Medical Officer and Assistant Vice President of Correctional Health Services for New York City Health and Hospitals Corporation. He also is a faculty member at the New York University Center for Survivors of Torture and co-chairs a federal

health advisory group on medical care for detainees. Dr. Venters has written and testified before Congress on the health risks of incarceration and the intersection between correctional health and human rights.

19. Brie Williams, M.D., is an Associate Professor of Medicine in the Division of Geriatrics at the University of California, San Francisco. She also is the Founding Director of the University of California Criminal Justice & Health Consortium, and the Director of the Criminal Justice and Health Project at the University of California, San Francisco. Dr. Williams has published work calling for a broader inclusion of prisoners in national health datasets and in health research funded by the National Institutes of Health, and for more scientific development of compassionate release policies.